STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This survey was for the investigation of Complaints IN00094836, IN00094325 and IN00093979. This visit resulted in a partially extended survey-immediate jeopardy. Complaint IN00094325-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309, and F 514. Complaint IN00094836-Substantiated. State finding related to the allegation are cited at F9999. Complaint IN00093979-Unsubstantiated due to lack of evidence. Survey dates: August 15, 16, 2011 Extended survey dates: August 17, 18, 19, 2011 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Ann Armey, RN- TC Rick Blain, RN (August 16,17, 2011) Sue Brooker, RD (August 16, 2011) Census bed type:	F0000	Enclosed is the plan of correction for the survey completed at Wesley Healthcare Inc. on 08-21-11. Please consider this the facility's credible allegation of compliance. However, submission of this response and the plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission of interest against the facility, the administrator or any employees, agent or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Rather this plan of correction has been prepared because the law requires us to prepare a plan of correction for the citations regarless of wehter we agree with them.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 44 Total: 44 Census payor type: Medicare: 3 Medicaid: 30 Other: 11 Total: 44 Sample: 7 Supplemental Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 23, 2011 by Bev Faulkner, RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician orders for respiratory assessments. This deficiency affected 1 of 4 residents reviewed who were ventilator dependent. (Resident #B) Findings include:	F0282	F0282It is the policy of Wesley Healthcare to develop and implement policies and procedures to follow all respiratory orders. Please consider this the facility's credible allegation of compliance as of 08/22/11. However, submission of this response and the plan of correction is not a legal admission	08/22/2011

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	The clinical record of Resident #B was reviewed on 8/15/11 at 3:30 p.m., and indicated the resident was admitted to the facility from the hospital on 7/18/11, following a laparoscopic cholecystectomy. The resident had diagnoses, which included but were not limited to, VDRF (Ventilator Dependent Respiratory Failure) and quadriplegia following a spinal cord injury. Admission respiratory orders, dated 7/18/11, indicated, among other things, that the resident was to have respiratory assessments every six hours with vent checks. Respiratory assessments were reviewed and the resident had a respiratory assessment on 7/27/11 at 7:35 p.m. The next respiratory assessment was done on 7/28/11 at 4:25 a.m., nine hours later. A respiratory note, dated 7/28/11 at 4:30 a.m., indicated CNAs were packing the resident in ice. The note indicated the resident's heart rate was 157, the oxygen saturation rate was 85 percent, oxygen was increased to 6 liters, and saturation rates remained in the "low 90's." The note indicated the resident was "in no respiratory distress." The respiratory noted indicated Resident		that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agent, or other individuals who draft or may be discussed in this response and plan of removal.REMEDY:On 08/22/11 a Patient-Ventilator System check policy was rewritten to insure a complete, consistant and timely ventilator system check for every respiratory patient in the facility. As of 08/22/11 all Respiratory Therapist were inserviced on the rewritten policy (see attached).MONITORING:DON or Designee to read all residents' Respiratory Assessme nt Sheet/Ventilator Monitoring Record forms with Tracheotomy or Ventilator Dependence daily for 30 days, reviewing for proper documentation and intervals as ordered. Any results outside of policy for Patient Ventilator System Checks needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly QA for review.DON or Designee to read 50% all residents' Respiratory Assessme nt Sheet/Ventilator Monitoring Record forms with Tracheotomy or Ventilator Dependence daily	

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	#B was taken by ambulance to the emergency room. On 8/16/11 at 10:30 a.m., the Director of Respiratory Therapy was interviewed. She indicated she talked to Respiratory Therapist #2, who was on duty during the night shift on 7/28/11, and asked her why she had not done Resident #B's respiratory assessment earlier. The Director of Respiratory Therapy indicated the therapist told her she had a very busy night and could not get in sooner to assess Resident #B's respiratory status. This Federal tag related to Complaint IN00094325. 3.1-35(g)(2)		for the next 30 days, reviewing for proper documentation and intervals as ordered. Any results outside of policy for Patient Ventilator System Checks needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly QA for review.DON or Designee to read 25% all residents' Respiratory Assessme nt Sheet/Ventilator Monitoring Record forms with Tracheotomy or Ventilator Dependence daily for the next 30 days, reviewing for proper documentation and intervals as ordered. Any results outside of policy for Patient Ventilator System Checks needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly QA for review.DON or Designee to read 25% all residents' Respiratory Assessme nt Sheet/Ventilator Monitoring Record forms with Tracheotomy or Ventilator Dependence daily for the next 2 quarters, reviewing for proper documentation and intervals as ordered. Any results outside of policy for Patient Ventilator System Checks needs to be immediately reported to the	

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			DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly QA for review.	
F0309 SS=J	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interviews and record review, the facility failed to provide appropriate treatment to a resident with an elevated temperature, resulting in death. This deficiency affected 1 of 3 residents, whose clinical records were reviewed following their deaths, in a sample of 7. (Resident #B) The immediate jeopardy began on 7/28/11, after the facility failed to notify the physician regarding a resident with an elevated temperature that did not respond to treatment. The Administrator, Director of Nursing and Chief Financial Officer were notified of the immediate jeopardy on 8/16/11 at 4:10 p.m. The immediate jeopardy was removed on 8/19/11, but noncompliance remained at the level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.	F0309	It is the policy of Wesley Healthcare to develop and implement policies and procedures to immediately inform/consult with the resident's physician were there is a potential of requiri8ng a physician intervention; a significant change in the resident's physical status: dererioration in health or clinical condition; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). Please consider this the facility's credible allegation of compliance as of 08/22/11. However, submission of this response and the plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agent, or other individuals who draft or may be discussed in this response and plan of	08/24/2011

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	Findings include: The clinical record of Resident #B was reviewed on 8/15/11 at 3:30 p.m., and indicated the resident was admitted to the facility on 7/3/11, with diagnoses which included but were not limited to, VDRF (Vent Dependent Respiratory Failure), and spinal cord injury with quadriplegia. In addition, Resident #B received enteral feeding via a PEG tube (Percutaneous Enteral Gastrostomy) tube, had a supra pubic urinary catheter and had a PICC (Peripherally Inserted Central Catheter) line. On 7/8/11, Resident #B verbally requested a "Full Code" which indicated, "I request that all efforts be made to prolong my life." On 7/9/11, a Patient Transfer Form indicated Resident #B was transferred from the facility to the hospital with and increased heart rate, an increased temperature and a decreased level of consciousness. A Hospital Surgical report indicated the resident had chronic cholecystitis and a laparoscopic cholecystectomy was performed on 7/12/11.		correction.All residents in the facility have the potential to be affected by the cited deficiency. Resident B was tranferred to Dekalb Memorial Hospital on 07/28/11. No ohter residents were affected.REMEDY:The incident in question occurred in the early morning of 07/28/11 and was reported to the Director of Nursing at 08:00 AM on 07/28/11, the Director of Nursing met with the Executive Director and Adminstrator and discussed disciplinary actions for RN #1. It was decided to terminate employment of RN #1. Incident was reported to ISDH on 07/28/11. RN #1 was terminated 07/28/11. Director of Nursing revised policy and procedure for treatment of elevated temperatures on 08/01/11.D.O.N spoke with rounding physician Dr. Ingram on 08/03/11 regarding revised policy and procedure for Elevated Temperatures. Dr Ingram changed the wording "that if oral temperature is greater than 104 degree it's a medical emergency call physician immediately" to "if oral temerature is 104 or greater call physician immediately". Dr. Ingram indicated that he was OK with the policy but requested to take a copy back to discuss with his partners that also round at the facility. Elevated Temperature Flow Sheets were posted on all medication carts at both nurses' stations, in the employee	

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	A respiratory note, dated 7/18/11 at 2025 (8:25 p.m.), indicated Resident #B was readmitted to the facility via emergency medical services and was placed on a facility ventilator. Admission respiratory orders, dated 7/18/11, indicated, among other things, that the resident was to have respiratory assessments every six hours with vent checks. Additional admission orders, dated 7/18/11, indicated the resident had diagnoses which included including but not limited to, left lower lobe pneumonia, Clostridium Difficile colitis and a Stage IV decubitus ulcer. The admission orders indicated the resident was to receive the following antibiotics: Daptomycin 300 mg, 50 cc intravenously every day for seven days, Vancomycin oral suspension 250 mg per PEG every six hours and metronidazole 500 mg per PEG every six hours. Nursing notes for 7/28/11, indicated the following: At 1:30 a.m., Resident #B's temperature was 101.6 degrees F (Fahrenheit) and she was given Tylenol and a sponge bath. At 2:30 a.m., the resident's temperature was 102.6 degrees F. "Will continue to		breakroom and at the time clock. Nursing staff was in-serviced on the policy and given a copy on 08/03/11.Dr. Chase Medical Director was contacted on 08/16/11 regarding the policy on Elevated Temperatures. Dr. Chase approved and signed the policy on Elevated Temperature on 08/16/11. Nursing staff was re-inserviced on policy and given a copy on 08/16/11.Dr. Ingram signed a statement confirming that he reviewed the Elevated Temperature aPolicy on 08/03/11 he approved changes made but preferred to have the policy reviewed by his partners.MONITORING:DON or Designee to read all residents' Nursing Notes daily for 30 days. Any results outside of policy for Elevated Temperatures needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly Infection Control/Quality Assurance for review.DON or Designee to read 50% all residents' Nursing Notes with Tracheotomy or Ventilator Dependence daily for the next 30 days. Any results outside of policy for Elevated Temperature needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents	

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	monitor." At 3:15 a.m., the temperature was 103.4 degrees F. "Cold wet compresses applied to axilla (arm pits) & (and) groin & sponged down c (with) damp wash cloth approx (approximately) q (every) 15-20 min. (minutes) ongoing." At 4:15 a.m., the temperature was 104 degrees F. "Continuing to monitor & (and) sponge bath." At 4:35 a.m., Resident #B's temperature was 106.7. The note indicated the resident's eyes were open and she looked at staff, but she did not respond. At 4:36 a.m., the physician was paged. At 4:37 a.m., the physician called the facility and an order was received to call 911. At 4:50 a.m., Resident #B was transported to the hospital via Emergency Medical Services. There was no documentation the physician was immediately notified, when Resident #B's temperature continued to rise, after receiving Tylenol and the sponge bath.		outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly Infection Control/Quality Assurance for review.DON or Designee to read 25% all residents' Nursing Notes with Tracheotomy or Ventilator Dependence daily for the next 30 days. Any results outside of policy for Elevated Temperatures needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly Infection Control/Quality Assurance for review.DON or Designee to read 25% all residents' Nursing Notes with Tracheotomy or Ventilator Dependence daily for the next 2 quarters. Any results outside of policy for Patient Ventilator System Checks needs to be immediately reported to the DON, Administrator or there Designee. Disciplinary action for all incidents outside policy will be taken immediately. All results from monitoring to be compiled and presented to quarterly Infection Control/Quality Assurance for review.	

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	Respiratory assessments were reviewed and the resident had a respiratory assessment on 7/27/11 at 7:35 p.m. The next respiratory assessment was done on 7/28/11 at 4:25 a.m., nine hours later. A respiratory note, dated 7/28/11 at 4:30 a.m., indicated CNAs were packing the resident in ice. The note indicated the resident's heart rate was 157, the oxygen saturation rate was 85 percent, oxygen was increased to 6 liters, and saturation rates remained in the "low 90's." The note indicated the resident was "in no respiratory distress." The respiratory noted indicated Resident #B was taken by ambulance to the emergency room. The Emergency Room Report, dated 7/28/11, indicated Resident #B went into full arrest enroute to a Fort Wayne Hospital, Cardio Pulmonary Resuscitation was initiated and the resident was rerouted to the local hospital. The report indicated the resident's temperature, upon arrival at 5:15 a.m., was 106 degrees, the pupils were fixed and... "After 14 minutes of true arrest situation with the rapid decline in her condition...Code was terminated at 06:00 hours" and the resident was pronounced dead. The report indicated the coroner was			

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	contacted because the resident was initially a victim of assault and had a recent laparoscopic cholecystectomy. The emergency room report assessment indicated "Cardiopulmonary arrest, secondary to sepsis in light of fever/recurrent multi-drug resistant organism urinary tract infections in the past." On 8/15/11 at 4:30 p.m., the DON (Director of Nursing) indicated RN #1, who had been on duty during the incident on 7/28/11, was terminated because she did not call the physician until the resident was unresponsive with a temperature of 106 degrees. She indicated the incident was reported to the ISDH (Indiana State Department of Health) on 7/29/11. On 8/16/11 at 3:30 p.m., the DON indicated Resident #B had a temperature of 101 at 1:30 a.m., Tylenol was given and an hour later the temperature had gone up. The DON indicated cold compresses should have been applied, the temperature retaken in 15-30 minutes, and the doctor called if there was no response to the treatment. The DON indicated a new policy for elevated temperature was written, shown to the Physician on 8/1/11, the Physician changed some of the wording and took a copy of the policy so it could be discussed			

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	by his partners. She indicated all the nurses had been inserviced on the policy, except one nurse, who was currently on vacation. The policy in effect at the time of the incident, entitled Observations To Report To The Physician, illegible date, provided by the DON was reviewed on 8/16/11 at 4:00 p.m., and indicated: "...The following examples of change in condition are...to provide the licensed nurse with guidelines to follow on physician notification....increases or decreases in temperature...." The immediate jeopardy that began on 7/28/11 was removed on 8/19/11, when the facility ensured new procedures were in place and staff were knowledgeable of the current policies and procedures for physician notification and respiratory assessment, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need to provide ongoing monitoring of the care provided to residents who have elevated temperatures and who require respiratory assessments. This Federal tag related to Complaint IN00094325.			

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	3.1-37(a)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to write a physician's order. This deficiency affected 1 of 7 residents, who received physician orders in a sample of 7. (Resident #B) Findings include: The clinical record of Resident #B was reviewed on 8/15/11 at 3:30 p.m., and indicated the resident was admitted to the facility from the hospital on 7/18/11, following a laparoscopic cholecystectomy. The resident had diagnoses which included but were not limited to, VDRF (Ventilator Dependent Respiratory Failure), quadriplegia following a spinal cord injury, and history of seizure disorder. On 7/25/11 at 3:30 p.m., nursing notes indicated Resident #B was exhibiting a	F0514	F514It is the policy of Wesley Healthcare that all telephone orders are dictated, transcriged accurateley, documented, and communicated to the responsible party.All residents in the facility have the potential to be affected by the cited deficiency. Resiedent B was transferered to Dekalb Memorial Hospital on 07/28/11. No other residents were affected.All Nurses and Respiratory Therapist (R.T.'s) have been inserviced on the Policy and Procedure for Telephone Orders. All new Nurses and R.T.'s will also be insericed on the Policy/Procedure with their new employee orientation.The D.O.N. or designee will review the Resident Notes five days per week for the first month and conduct an audit of any new orders to ensure that orders are dictated, transcribed appropriately, documented in Resient Notes, and responsible party notification. D.O.N. will review the resuts of the Telephone Order Audit at each	08/24/2011

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	blank stare, arterial blood gases had been drawn by the respiratory therapist and the results of the arterial blood gases indicated the resident had high levels of carbon dioxide in the blood. The nursing notes indicated the pulmonologist had been contacted and new orders were received to "hold Klonopin (a medication used for seizures) et (and) Methadone (a medication used for severe pain) this evening et (and) vent settings adjusted. If 0 (zero) improvement by this evening, notify (Pulmonologist's Name) as resident may need sent out for head CT (Computed Tomography)." The July MAR 2011 (Medication Administration Record) indicated the evening doses of Methadone and Klonopin had been held on 7/25/11. In addition the Respiratory Assessment Sheets indicated the ventilator setting had been changed on 7/25/11 to full assist control ventilation, with an increase in the respiratory/vent rate (12 to 15) and an increased (tidal) volume (450 to 500). Laboratory reports, dated 7/25/11 at 22:52 (10:52 p.m.), indicated the resident's arterial blood gas results had improved. There was no documentation a physician's telephone order was written on 7/25/11, as indicated in the nursing notes, including		quarterly Quality Assurance meeting for compliance.The D.O.N. or designee will review the Resident Notes three days per week for the next two month and conduct an audit of any new orders to ensure that orders are dictated, transcribed appropriately, documented in Resient Notes, and responsible party notification. D.O.N. will review the resuts of the Telephone Order Audit at each quarterly Quality Assurance meeting for compliance.The D.O.N. or designee will review the Resident Notes one day per week for the next two quarters and conduct an audit of any new orders to ensure that orders are dictated, transcribed appropriately, documented in Resient Notes, and responsible party notification. D.O.N. will review the resuts of the Telephone Order Audit at each quarterly Quality Assurance meeting for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING 00 B. WING	08/19/2011

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	the specific vent setting orders. On 8/16/11 at 11:25 a.m., LPN #3, who wrote the nursing notes on 7/25/11, was interviewed. She indicated she contacted the physician and thought she had written the telephone orders so they could be signed by the physician. On 8/16/11 at 4:30 p.m., the Director of Nursing indicated they had checked the closed record but were unable to find the telephone orders. The Policy/Procedure for Telephone Orders, dated 10/5/09, provided by the Director of Nursing , was reviewed on 8/18/11 at 2:00 p.m.,and indicated: "1. Nurse dictates order on a telephone order sheet... 8. White copy is then placed back in the chart after it is signed." This Federal tag related to Complaint IN00094325. 3.1-50(a)			

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F9999	STATE FINDINGS 3.1-14 PERSONNEL (o) Inservice records shall be maintained and shall indicated the following: (5) The program content of inservice. This state rule was not met as evidence by: Based on observation, interview, and record review, the facility failed to provide the program content of the orientation inservice provided to staff who worked on the RCU (Respiratory Care Unit). Findings include: On 8/16//11 at 9:00 a.m., a ventilator dependent resident (Resident #E) was observed receiving a shower. The resident was removed from the ventilator by the Director of Respiratory Therapy and CNA #4 provided respirations via an ambu bag, while CNA #5 showered the resident. On 8/16/11 at 9:35 a.m., CNA #5 indicated she had received training regarding the use of the ambu bag for ventilator dependent residents. On 8/17/11 at 4:30 p.m., the DON	F9999	F9999It is the policy of Wesley Healthcare to provide adequate Inservice training for all staff along with providing adequate program content.A revised policy has been put into place for bathing guests who are ventilator dependant. All C.N.A's and R.T.'s have been trained on this procedure. All new C.N.A.'s and R.T.'s will be provided with specific training in new employee orientation.The Director of Nursing and Lead Respiratory Therapist will continue to develop specific training content to be used for orientation of new C.N.A.'s and R.T.'s The Medical Director of the R.C.U unit will review any new program content.The Director of Nursing or designee will conduct daily rounds five days per week for the first month; then one time per week for the next 5 months to ensure that R.C.U. staff have been adequately trained and Policies/Procedure are in place.The D.O. N. will review results at the quarterly Quality Assurance Meeting for six month to ensure compliance.	08/27/2011

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	indicated the facility had no specific procedure for bathing ventilator dependent residents, but each CNA received training from a respiratory therapist, before working on the RCU. The DON indicated she was not able to find specific content information used for the inservice/orientation to the RCU, but a competency check list was signed. On 8/17/11 at 4:35 p.m., the competency check list was reviewed and included the following topics: Portable oxygen Positioning vent circuits Low pressure monitor Ambu bag and flow Scent free environment When to call RT On 8/18/11 at 1:30 p.m., the DON indicated there was no written information about what was to be covered in the inservice/orientation to the RCU (Respiratory Care Unit). She indicated she and the Director of Respiratory Therapy were developing a specific outline of the training content to be used for orienting CNAs to the RCU. The DON indicated this would assure consistency in the information provided by respiratory therapist's to the CNAs. This State finding relates to Complaint			

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	IN00094836. 3.1-14(o)(5)			